BIKAN S OCTAIN M.D.P.C.

PATIENT REGISTRATION

Name

Patient name | SS #

Street Address | Date of Birth | Marital Status

City | State Alabama | Zip

Tel # Home | Office

Referred by | Cell #

Spouse's name | Email

Spouse's Employer/Address

Emergency Contact | Tel. # | Relationship

PATIENT EMPLOYER INFORMATION

Employer Name | Tel.#

Employer Street Address | City/State Alabama | Zip

Patient's Occupation

INSURED PERSON (IF NOT PATIENT)

Name | Work Tel.#

DATE OF BIRTH | **S.S.N. #**

Relationship to Patient | Employer name

INSURANCE

Medicaid #(if applicable) | Medicare #(if applicable)

Primary insurance co. name

ID # | Group # | Phone #

Secondary insurance co. name

ID # | Group # | Phone #

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date | Signature

I hereby authorize Dr. BIKAN S OCTAIN M.D. to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my company be made directly to Dr.
(or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date | Signature

Patient, Parent or Guardian